BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **PETER JAMES NORMANN, M.D.** Holder of License No. **33254** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-07-0328A** **MD-07-0589A** **AMENDED INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") on July 10, 2007. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against the license of Peter James Normann, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board entered Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action. A.R.S. § 32-1451(D). On July 12, 2007 the Board issued amended the Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action to incorporate its finding that the facts as presented demonstrate that the public health, safety or welfare imperatively requires emergency action.

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 33254 for the practice of allopathic medicine in the State of Arizona.

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3. The Board initiated case number MD-07-0328A on May 1, 2007 after being notified that two of Respondent's patients RG, a thirty-three year-old male and AS, a forty-one year-old

female, were brought to a hospital's emergency department over a four month period after suffering cardiac arrest during liposuction procedures performed by Respondent at his office. Both patients died.

4. RG was an otherwise healthy male who presented to Respondent's office on March 10, 2006 for an initial consultation for liposuction of the abdomen and waist. RG was seen again on May 3, 2006 for a pre-op visit. Respondent performed surgery in his office on May 16, 2006 under local (tumescent) anesthesia with minimal p.o. sedation except that Respondent gave Demerol 50 mg and Phenergan 25 mg IM at the very end of the procedure. RG was discharged home approximately twenty-five minutes after the surgery ended. RG recovered uneventfully and subsequent follow-up was unremarkable. RG was again seen by Respondent on December 4, 2006 and plans were made for repeat liposuction of the same areas treated on May 16, 2006. It is not clear from the records whether the indication for the repeat procedure was residual or re-accumulated fat.

5. Respondent performed the repeat procedure in his office on December 12, 2006 using a propofol drip and IV ketamine for conscious sedation since RG had experienced significant pain during the first procedure. Approximately thirty-five minutes into the procedure RG experienced oxygen desaturation followed by cardiac arrest. Respondent's staff called 911 and Respondent began a code. Respondent intubated and ventilated RG with an ambu bag and gave atropine, epinephrine and Lidocaine. Emergency medical technicians ("EMT") arrived within a few minutes of the 911 call to find cardio pulmonary resuscitation ("CPR") in progress. An EMT was unable to verify breath sounds on auscultation of the chest and so advised Respondent. The EMT also noted RG's abdomen was severely distended, but Respondent told him it was due to the two liters of tumescent solution injected into RG's subcutaneous abdominal fat. RG was then transported in persistent full arrest to the local hospital.

6. Respondent insisted on riding along and re-intubated RG just before arrival at the hospital. The EMT still could not verify breath sounds, but Respondent told him the "tube was good." RG was turned over to hospital staff in complete arrest, mottled, and without positive tube placement. RG's pupils were noted to be fixed and dilated and a CO2 sensor indicated incorrect endotracheal tube placement. Hospital staff reintubated RG and the CO2 sensor immediately indicated proper tube placement. RG was pronounced dead shortly thereafter.

7. The Medical Examiner ruled RG's death a result of an adverse reaction to medications administered for cosmetic liposuction. The Medical Examiner found RG to be otherwise previously healthy, found no evidence of cardiac or pulmonary disease, found no evidence of pulmonary emboli or myocardial infarction and found no evidence of an anaphylactoid reaction.

8. AS, an otherwise healthy female presented to Respondent's office on September 9, 2006 and was seen by a licensed massage therapist ("LMT") employed by Respondent as a medical assistant. Respondent was out of town attending a medical conference. AS next presented on September 25, 2006 and was seen by LMT in consultation for liposuction. The visit note is written and signed by LMT. AS's liposuction of the waist, abdomen, back and outer thighs was performed on September 27, 2006. LMT filled out and signed the intra-operative record. AS received eight liters of tumescent fluid, over six liters were aspirated and AS spent approximately twenty minutes in recovery before being sent home. AS received no resuscitative IV fluids and her urine output was not monitored. Respondent left for a trip to Germany two days after the surgery and all of the follow-up care was done by LMT. AS did not physically return for follow-up, but LMT placed calls to her. There is no operative note written by Respondent for AS's procedure and no documentation that Respondent ever participated in AS's pre-operative evaluation, surgery or follow-up.

9. On March 19, 2006 AS was seen in Respondent's office for a deflated right breast implant. Respondent handwrote and signed a brief note. Surgery was scheduled to replace the implant. On March 23, 2006 AS underwent that procedure under conscious sedation in Respondent's office. There is a typed operative note of the procedure, but it states both implants were replaced, not just the problematic right side. Respondent saw AS in follow-up at four and nine days post-op. The right breast implant was noted to be positioned too high on both visits. On the second visit, plans were made to return to surgery for touch-up liposuction of the abdomen and waist and for primary liposuction of the neck and breasts and fat injections to the buttocks. This surgery was done on April 13, 2007 under conscious sedation with IV ketamine and propofol drip. There is no operative note for this surgery; the intra-operative records are not signed, but appear to have been filled out by LMT. There is no record of vital signs taken in recovery or disposition of AS at discharge. The fat injections for buttock augmentation were not performed and there is no documentation why they were omitted. There is no documentation that Respondent participated in this surgery.

10. AS was seen for her first follow-up three days later on April 16, 2007. It appears that plans were made to perform the previously omitted fat injections that day, but then it was discovered that fat had not been saved from the previous liposuction surgery and the surgery was not performed. The surgery was rescheduled for a later date. AS was returned to surgery one week later during which she experienced oxygen desaturation and cardiac arrest. All of the documentation from Respondent's office is dated April 24, 2007, but all emergency medical service and hospital records are dated April 25, 2007. This surgery was done under conscious sedation with IV ketamine and a continuous propofol drip.

11. The "Liposuction Operative Note" from surgery indicates a plan to perform liposuction of the hips, revision of the right breast, and buttock augmentation. Review of the drawings on that sheet reveals all areas were injected with tumescent solution in anticipation of

surgery, including the buttocks. At the bottom of the sheet, there is a handwritten note that the buttock augmentation was not performed and AS coded after the breast revision and liposuction were performed. The "Conscious Sedation Record" shows the propofol drip was turned off at between 1735 and 1740 hours and AS coded some twenty or twenty-five minutes later at 1800. According to this record, the propofol drip was discontinued after the breast revision and liposuction was completed and well before AS arrested. The record is not consistent with a sequence of events in which the buttock augmentation was omitted as a result of the code, as implied by the handwritten note, and Respondent's account of the sequence of events (that AS arrested after the procedure had been completed) is not consistent with the records from surgery since all of planned procedures had not been completed. After AS arrested, 911 was called, and AS was intubated and ventilated and quickly went into asystole. CPR was begun, defibrillator pads were placed and she received epinephrine, atropine, flumazenil and narcan. AS was subsequently transported to the local hospital where a pulse and pressure were re-established, but she coded again and expired shortly after transfer to the CCU.

12. On May 3, 2007 Respondent signed an Interim Consent Agreement for Practice Restriction prohibiting him from performing office procedures or surgeries using conscious sedation until further Order of the Board.

13. During investigational interviews with Board Staff Respondent made several false statements. Respondent stated he did not do formal tummy tucks, but records of patient LL describe a full abdominoplasty with placation of the rectus sheath. Respondent stated his staff did not do any procedure without him first doing the consultation and approving the plan, but the medical records of numerous patients indicate they received treatment and office staff performed procedures during times Respondent was out of the office. Respondent stated his bookkeeper had no patient contact, but he later admitted she assisted in surgical procedures. Respondent stated LMT did not do any cutting of skin or suturing, but patient NL, an office employee, LMT and even

Respondent confirmed LMT sutured patients.

14. In every operative report in each patient file reviewed by Board Staff Respondent referred to his employees who assisted in procedures as "medical assistants," including his bookkeeper. None of Respondent's staff has completed an approved medical assistant training program nor met the qualifications for exemption under the applicable Administrative Rules.

15. Respondent facilitated the illegal practice of medicine by allowing LMT to perform liposuction, suture, perform post-operative examinations; allowing another employee, a former restaurant owner, to assist in twenty or twenty-five liposuction procedures, of which eight or ten were performed by LMT with Respondent present; and allowing a homeopathic physician not licensed as an allopathic physician by this Board to practice allopathic medicine.

16. Respondent dispensed medications to approximately fifteen patients on more than one occasion from February 2, 2007 through May 1, 2007. Respondent does not have a dispensing certificate from the Board.

17. Respondent was performing procedures involving laser equipment that was not registered with the Arizona Radiation Regulatory Agency.

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18. On July 9, 2007 the Board was informed by a local fire department that on July 3, 2007 they received a 911 call from Respondent's office requesting emergency response to a patient in cardiac arrest. This patient, LR, a fifty-three year-old female, later died at a local hospital. LR first presented to Respondent on May 22, 2007 for a consultation for a liposuction procedure. LR made three payments to Respondent, the last payment being made on July 3, 2007, the day of surgery.

19. Subsequent to signing the Interim Consent Agreement Respondent entered into an agreement with a licensed Homeopathic physician ("Homeopath"). Homeopath is not licensed by the Board as an allopathic physician. Respondent maintains: Homeopath evaluated LR the day of

the procedure and performed the procedure (liposuction of LR's thighs) using local tumescent anesthesia combined with IM morphine and Phenergan; the procedure began approximately 1:00 p.m. and completed at 5:50 p.m; LR was given IV normal saline; was ambulatory at 6:40 p.m. and vomited at 7:00 p.m.; Homeopath left the building at 7:10 p.m., leaving Respondent to monitor LR in recovery until her ride arrived. Respondent also maintains: LR was snoring loudly and at 9:50 p.m. he tried to arouse her from snoring, but was unable to do so; he started an IV and placed a tourniquet on her arm; he noticed LR had stopped snoring and breathing; he started CPR and called 911 at 10:07 p.m.; he used the defibrillator and it advised a shock was completed; his physical examination showed LR had spontaneous breath sounds, good color, but he could not feel a pulse or heart signs with a stethoscope; EMS arrived and took over LR's care. LR was transferred to a hospital where she later died. Fire Department records indicate when they responded the treating physician was Homeopath, but the records reflect and Respondent maintains, Homeopath had left the facility three hours earlier.

Standard of Care

20. The standard of care for a physician performing liposuction includes an appropriate preoperative evaluation, history and physical examination, explanation of benefits and risks, performance of the surgery in a safe and technically correct fashion and provision of appropriate post-operative care.

21. Respondent deviated from the standard of care by failing to perform appropriate preoperative evaluation, history and physical examination, explanation of benefits and risks, performance of the surgery in a safe and technically correct fashion and provision of appropriate post-operative care in a safe environment on multiple patients.

22. The standard of care requires a physician who is performing conscious sedation in the office using propofol to follow the American Society of Anesthesiologists ("ASA") Statement on Safe Use of Propofol, including employing certified and adequately trained personnel to monitor

the patients during surgery; being adequately educated and trained in the hours-long use of Propofol required for the liposuction procedures; being physically present while a patient is under conscious sedation; adequately monitor patients who are under conscious sedation; and demonstrate a complete understanding of propofol.

23. Respondent deviated from the standard of care by not employing certified and adequately trained personnel to monitor the patients during surgery; not being adequately educated and trained in the hours-long use of Propofol required for the liposuction procedures; not being physically present while a patient is under conscious sedation; not adequately monitoring patients who are under conscious sedation; and not demonstrating a complete understanding of propofol.

24. The standard of care requires a physician to employ certified or appropriately trained personnel to assist in surgery to provide a safe surgical environment.

25. Respondent deviated from the standard of care by failing to employ certified or appropriately trained personnel to assist in surgery and failing to provide a safe surgical environment.

26. The standard of care requires a physician to provide appropriate and timely post-operative care either personally or by appropriately supervised and trained personnel.

27. Respondent deviated from the standard of care by failing to provide appropriate and timely post-operative care to AS either personally or by appropriately supervised and trained personnel.

28. The standard of care requires a physician performing conscious sedation in the office to be adequately trained to address an emergent situation, including the ability to correctly intubate a patient.

29. Respondent deviated from the standard of care by failing to intubate RG correctly.

30. Three patients died.

Medical Records

31. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records do not meet this standard.

Finding of Imminent Harm

32. The facts as presented demonstrate that the public health, safety or welfare imperatively requires emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 33254 for the practice of allopathic medicine in the State of Arizona.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(a) ("[v]iolating any federal or state laws or rules and regulations applicable to the practice of medicine,") specifically, A.R.S. § 30-672; A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;") A.R.S. § 32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution;") A.R.S. § 32-1401(27)(cc) ("[m]aintaining a professional connection with or lending one's name to enhance or continue the activities of an illegal practitioner of medicine;") A.R.S. § 32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written

correspondence, including attachments, with the board;") A.R.S. § 32-1401(27)(kk) ("[f]ailing to dispense drugs and devices in compliance with article 6 of this chapter;") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence, or negligence resulting in harm to or the death of a patient.").

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above, IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 33254, is summarily suspended pending a formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED this 12 day of July 2007

[SEAL]

ARIZONA MEDICAL BOARD

By _____
Timothy C. Miller, J.D.
Executive Director

ORIGINAL of the foregoing filed this 12th day of July 2007, with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

EXECUTED COPY of the foregoing mailed by US Mail this 12th day of July 2007 to:

Peter James Normann, M.D.
Address of Record

and

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Assistant Attorney General
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